Innovative Solutions to Admission Workload: C902
Baylor Regional Medical Center at Grapevine

2015 ANCC National Magnet Conference
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Hospital Overview

Baylor Regional Medical Center at Grapevine

Key Service Lines
Recognized by the Industry

Our Service Area

The Call to Action

• Inpatient Admission Workload/Patient Safety
  – AHRQ Patient Safety Feedback
  – Admissions process took 35–45 minutes to complete
  – Batched from 1500 to 2100 – overwhelmed at change of shift
  – Feeling short staffed due to ADT index
  – NDNQI RN Satisfaction supported the above
  – Nursing Forums
  – Q12 surveys speak to admission workload burden
  – Beth’s Bistros and unit rounding
  – No “Golden Hour” at change of shift
  – Right patient, right bed/unit . . . every time
  – Measure reduction of RRT within 24 hours of admission
The Call to Action

• **ED Admission Workload**
  – EHR incompatibility – MedHost to Allscripts
  – Orders lost in admission process
  – Delay in STAT orders
  – Med reconciliation – duplicative, time consuming and often not completed
  – ED received significant inpatient pushback during shift change

The Call to Action

• **Service Opportunity** – System focus on ED crisis admission - lower HCAHPS scores
  – Lost in the shuffle
  – Transition to inpatient world poorly managed
    • ED RNs unable to answer inpatient questions
  – Continuity of care – completing stat orders, adequate RN to RN hand-off

Brainstorming – October 2013

• **Status Quo not an option**
• CNO/Director level discussion of potential workload solutions
• Developed concept and a name
  – “A Team” – group of leaders who address excellence on several levels and manage admission workload
Challenge to the CNO

- Budget neutral solution – modify RRT model to “A Team” with broadened scope
- Solution aimed to lessen workload across the hospital without inadvertently creating new problems
  - Efficiency – inpatient resource floating across units
- Couldn’t be viewed as a takeaway – needed to manage ALL perspectives of the change

Kris Rabenold, MSN, RN, CNML
Acute Care and Women & Children’s Director

Programmatic Must Haves

- Establish coverage of admissions
  - Capture 80% of all admits
  - Establish the vision before staffing the team
- Establish metrics to identify if we made a difference
  - Q12 survey – Included targeted questions around workload, patient satisfaction & quality of care
Developing the “A Team”

• Immediate Problems
  – Current RRT nurses were not willing to change with the model - lost our RRT experience
    • Bedside leaders pulled into the noise of change
  – Could not let history get in the way of innovation
  – Where was this program going to be housed?
    • Vacant inpatient unit - patients moved many times
    • ED staff absorbed in emergency care - would interfere with throughput and patient flow
Developing the “A Team”

• “A Team” Competency Considerations
  – PCU or ICU experienced RNs
  – ACLS and RRT trained
  – High performers
  – Flexible attitude and demeanor
  – Strong service skills
  – Appropriate documentation – new skill set

• Managing the worst-case scenario “what if’s”
  – Who was the safety net if several things occurring at once?

Developing the “A Team”

• Communication Clarity
  – Educating/hardwiring that all admissions are not facilitated by the “A Team”
  – Nurses on inpatient side still owned admission pieces
    • Orient to room, bed, call light, unit specific concerns, meal process, finish med reconciliation, and any clinical hand-off information
  – Developed the “Red Sheet” hand-off communication tool

“A Team” Checklist

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<th>Item</th>
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<td>Items left to complete admission</td>
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<td>Time to complete admission</td>
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Developing the “A Team”

• Managing our ICU Medical Director
  – Not happy the proactive RRT program was being modified
  – Strong working relationship with RRT personnel through history and mentoring

• Hiring, Onboarding and Developing “A Team”
  – ICU / A Team mentorship to RRT duties
    • ICU ran RRT for 6 weeks – “A Team” observed
    • “A Team” ran RRT for 1 month – ICU coaching

Developing the “A Team”

• Brainstormed roles and responsibilities
  – ED admissions only/not direct admits. Didn’t want the “A Team” lost in the inpatient or ED side of workflow
  – RRT
    – Inpatient discharge resource if not busy
      • Dispatched by house supervisors

“A Team” Go Live Considerations

January 2014

• Distinguished by Red Polo shirt
• ED team acceptance was a challenge initially
• Couldn’t hear overhead for RRT/Code Blue calls while in ED patient rooms – special phone provided
• Needed access to ED documentation system
“A Team” Go Live Considerations

• Everyone wanted a “piece” of the “A Team”
  – Held firm boundaries – ED Med Dir, ICU, ED, Inpatient, Quality, Risk Management, Stroke Program
  – Remained true to the mission; helped “A Team” members feel comfortable with saying “no”
• “A Team” was slow to adapt to inpatient communication needs
• ED bedside leaders weren’t utilizing communication tools

Anna Schlatter, BSN, RN
Director of ED and Nursing Administration

Launching the “A Team” in the ED

• Concerns and Considerations
  – Space
  – Team dynamics
  – Patient flow / throughput in the ED
    • Would the admission process hold up moving patients out of the department in a timely manner?
    • Teaching the physicians to queue up the admission with the “A Team” early in the ED visit
Physician Considerations

• Early identification of admissions
  – Communication to “A Team” prior to written order
  – Scripting with patient / family – performing the admission incognito prior to physician
    communication
• Communication with physicians re: proper bed placement – always asking does this make sense?
• Ensuring physicians were not providing verbal orders directly to the “A Team”
• Requesting the “A Team” to transport patients

Bedside Leader Considerations

• Ensuring that ED staff and the “A Team” weren’t bombarding the patient at the same time – each
  serves different purposes
  – Developed team queues
• Managing the verbiage – observation status versus regular admit
• Who sits where? – turf considerations
• Computer availability – consider this early
• Requesting the “A Team” perform ED tasks

“A Team” Considerations

• Needed a “home” in the ED
  – Lockers, access to staff lounge, supply rooms, etc.
• “A Team” sick calls were covered RRT by ICU nurses - this was a point of irritation
• Team integration took time
  – Incoming “A Team” phone calls weren’t properly routed
Programmatic Outcomes

- RRT – Concern that the RRT model change would negatively impact the number of RRT calls – did not happen
- Mortality - Improved
- Right patient, right bed – Improved
- Patient Satisfaction / ED Crisis Admits - Improved
- Number of admissions captured by “A Team” – exceeded goal
- Q12 – Very positive results

RRT Trending with Model Change
Mortality Trending

Right Patient, Right Bed

ED Crisis Admits
Did We Capture 80% of Admits CY14?

- CY 14 A Team Admissions
- A Team
- Avg ED admission/day

84%

Did We Capture 80% of Admits CY 15?

- CY 15 A Team Admissions
- A Team
- Avg ED admission/day

81%

Q12 Results
Pearls

• Think from the perspective of “What is in it for me?” when socializing to stakeholders
• Create the chaos on the front end
• Celebrate the wins - inpatient and ED bedside leaders were thrilled
• Don’t let history get in the way of innovation
• Lost one “A Team” member to the ED
  – Fell in love with the ED team and practice

Members of the “A Team”

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